PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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<tr><td colspan="4">Policy/Procedure Title: Claims Processing and Payment Standards for Partnership</td><td colspan="3">☒External Policy
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<tr><td colspan="4">Approval Signature: Lisa Malvo</td><td colspan="3">Approval Date: 09/1/2026</td></tr>
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I. RELATED POLICIES:

A. CMP-36 Delegate Oversight

II. IMPACTED DEPTS:

A. Claims

III. DEFINITIONS:

A. N/A

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To document the timely and accuracy guidelines for the Partnership Claims Department in accordance with Partnership contracts and regulatory requirements.

VI. POLICY / PROCEDURE:

A. Partnership HealthPlan of California (Partnership) Claims Department will meet Department of Health Care Services (DHCS) contract requirements as outlined below. Where claims processing is delegated to another entity, the delegated entity must also comply with standards outlined below.

B. Medi-Cal Line of Business

1. Claims mail will be opened, sorted, date stamped, Claim Control Number (CCN) assigned, scanned and prepared for processing within two days of receipt.
2. Electronic claims are acknowledged via the HIPAA 997 acknowledgement transmission and the 277 within two (2) working days of receipt of the electronic claims. Paper claims are acknowledged within 15 working days.
3. Claims that are incorrectly sent to Partnership but are the financial responsibility of one of Partnership's capitated providers are forwarded to the capitated provider within 10 working days from receipt. The billing provider is also sent notification indicating where to submit claim.
4. Partnership shall pay all clean claims submitted by network providers in accordance with this section, unless the network provider and Partnership have agreed in writing to an alternate payment schedule, subject to the following:

a. Partnership shall comply with 42 USC section 1396u-2(f) and H & S Code sections 1371 – 1371.36 and their implementing regulations. Partnership shall be subject to any penalties and sanctions, including interest payments, provided by law if Partnership fails to meet the standards specified in this section.

5. Partnership shall maintain procedures for pre-payment and post-payment claims review, including review of any data associated with providers, members, and the covered services for which payment is claimed.
6. Partnership shall maintain sufficient claims processing, tracking, and payment systems capability to comply with applicable State and Federal law, regulations, and contract requirements, to determine the status of received claims and to estimate incurred and unreported claims (IBNR) amounts as specified by 28 CCR sections 1300.77.1 and 1300.77.2.
7. 95% of clean claims submitted by contracted or non-contracted providers, for which no further written documentation or substantiation is required, are processed and paid or denied within 45 working days after receipt.
8. Partnership will pay 90% of all clean claims from the practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99% of all clean claims within 90 days. The date of receipt shall be the date Partnership receives the claim, as indicated by the date stamp on the claim. The date of payment shall be the date of the check or other form of payment.
9. Providers will be notified within 15 working days of receipt of the paper claim status, i.e., paid, pended, or denied via the weekly Partnership Remittance Advice (RA) Paid/Denied or Pend Report. Providers can also access this information via the Partnership e-Claim Inquiry System on the Partnership website for both paper and electronic claims.
10. Late payment on a complete claim for emergency services and care, which is neither contested nor denied, shall automatically include the greater of $15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15 percent per annum for the period of time that the payment is late. Late payments on all other complete claims shall automatically include interest at the rate of 15 percent per annum for the period of time that the payment is late.
    If Partnership fails to automatically include the interest due on a late claim payment, Partnership shall pay the provider $10 for that late claim in addition to interest owed for late payment.
    If the interest is not sent in the same envelope as the claim payment, Partnership or the subcontractor shall identify the specific claim or claims for which the interest payment is made, include a statement setting forth the method for calculating the interest on each claim and document the specific interest payment made for each claim within five (5) working days of payment.
11. 95% of CIFs for which no further written documentation or substantiation is required are processed within 45 working days from receipt.
12. Partnership will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.
13. Partnership will fully comply with Knox Keene Rule 1300.77.4. Rule 1300.77.4 requires that claim forms received by the plan from providers of health care services for reimbursement on a fee-for-service basis are maintained and accounted for in a manner which permits the determination of the date of receipt of any claim, the status of any claims, the dollar amount of unpaid claims at any time, and rapid retrieval of any claim.
    The date of receipt for electronic and paper claims is embedded in the Partnership Claim Control Number stamped on the claim, scanned and indexed into the imaging system and entered in the Partnership claims system.

The Partnership claims processing system can report the status of all claims in the system. The status determination categories include: paid, denied, and pended.

14. Partnership will identify and deny claims that exceed the one-year billing limit. The one-year billing limit will be calculated from the date of service on the claim to the date the claim is received by Partnership. The system will deny claims received on and after the 366th day from the date of service. See CLPM-05 and/or CLPM-06 for specific information regarding this.
15. Partnership processes claims submitted by its providers consistent with the Medi-Cal guidelines for Share of Cost (SOC) outlined in the Medi-Cal Provider Manual. When a member has a SOC, the billing provider will subtract the SOC payment collected or obligated payment from the claim amount and submit the claim to Partnership to pay the balance.
16. Because of the Johnson v. Rank lawsuit, Medi-Cal Members can elect to use the SOC funds to pay for necessary, non-covered, medical or remedial care services, supplies, equipment, and drugs (medical services) that are prescribed by a physician and part of the plan of care authorized by the Member's attending physician. The physician's prescriptions for SOC expenditures must be maintained in the Member's medical record. If a Member spends part of their SOC on necessary, non-covered, medical or remedial care services or items, the billing provider will subtract those amounts from a Member's SOC and collect the remaining SOC amount owned. The billing provider will adjust the amount on the claim and submit the claim to Partnership to pay the balance.
17. A medical service is considered a non-covered benefit if the medical service is rendered by a non-Medi-Cal provider; or the medical service falls into the category of services for which a Treatment Authorization Request (TAR) must be submitted and approved before Partnership will pay and either (1) a TAR is not submitted or (2) a TAR is submitted but is denied by Partnership because the service is not considered medically necessary.
18. Providers that collect SOC payments or obligated payments are responsible for certifying SOC in the Medi-Cal eligibility verification system to show the Member has paid or obligated payment for the monthly SOC amount owed. Instructions for Providers to perform SOC clearance transactions in the Medi-Cal eligibility verification system are provided in the DHCS Medi-Cal Provider Manual.

VII. Claims Payment Standards

A. Freestanding Birth Centers, Midwife Services, Certified Nurse Practitioners, Licensed Nutritionists

1. In accordance with 22 CCR section 51345 *et seq.* and APL 18-022, Partnership will pay all contracted Freestanding Birth Centers (FBC), Certified Nurse Mid-Wives (CNM), Licensed Midwives (LM), Certified Nurse Practitioners (CNP) or Licensed Nutritionists (LN) at their Partnership contracted rate. If the FBCs, CNMs, LMs, CNPs or LNs do not have a contract with Partnership or if there are no FBCs, CNMs, LMs, CNPs, or LNs available for services in Partnership's network, Partnership must reimburse the FBCs, CNMs, LMs, CNPs or LNs for services provided to Partnership members at no less than the applicable Medi-Cal Fee for Service rates. For hospitals, the requirements of Attachment III, Subsection 3.3.16.A.3 (Emergency Services and Post-Stabilization Care Services) if applicable, apply. For FBCs, Partnership must reimburse the non-contracting FBC at no less than the applicable Medi-Cal fee for service rate. If an appropriately licensed non-contracting FBC is used, Partnership must also pay the center's facility fee. Where claims processing for these services is delegated to another entity, the delegated entity must also comply with the standards outlined above.

B. Skilled Nursing Facilities and Nursing Facilities

1. In accordance with W & I Code section 14184.201(b) and for applicable dates of service,

Partnership shall reimburse an In-Network provider furnishing institutional long-term care services to a Partnership member the amount the provider could collect if the member accessed those services in the Medi-Cal fee for service delivery system, as defined by DHCS in the Medi-Cal State Plan, a Directed Payment Initiative, and other applicable guidance, including but not limited to guidance issued pursuant to W & I Code section 14184.102(d). As used in this provision, "institutional Long-term care services" has the same meaning as set forth in the CalAIM Terms and Conditions and, subject to W & I Code section 14184.102(f), includes, at a minimum, all of the following services:

a. Skilled nursing facility services;
b. Subacute facility services;
c. Pediatric subacute facility services; and
d. Intermediate care facility services.

Where claims processing for these services is delegated to another entity, the delegated entity must also comply with the standards outlined above.

2. Fee-for-service per diem rates remain effective for subsequent dates of service until an updated per diem rate is published for subsequent dates of service. Partnership will implement any changes to rates for all facilities listed above made by DHCS on a prospective basis for all claims with applicable dates of service received on or after 30 working days of being notified by DHCS that the rates have been published. Partnership will make any retroactive adjustments within 45 working days of being notified by DHCS that the updated rates have been published. These retroactive adjustments will be made automatically without requiring manual reprocessing or resubmission by the provider. This applies to both contracted and non-contracted providers.

3. Timely payment of claims applies to Network Providers and Out-of-Network Providers when those dates of service were under continuity of care.

4. Providers should bill Partnership their total billed charge less any applicable share of cost. In the event a provider does not deduct the member share of cost, a retroactive share of cost audit is done to recoup the overpayment.

C. Intermediate Care Facilities (ICF/DD, ICF/DD/H, ICF/DD/N)

1. In accordance with APL 24-011, Partnership must pay timely in accordance with the prompt payment standards within our contract and APL 23-020, Requirements for Timely Payments of Claims, or any superseding APL. Fee for Service per diem rates remain effective for subsequent dates of service until an updated per diem rate is published for subsequent dates of service. Partnership will implement any changes to rates made by DHCS on a prospective basis for all claims with applicable dates of service received on or after 30 working days of being notified by DHCS that the rates have been published. Partnership will pay any retroactive adjustments within 45 working days of being notified by DHCS that the rates have been published. These retroactive adjustments will be made automatically without requiring manual reprocessing or resubmission by the provider. This applies to both contracted and non-contracted providers.

   Providers should bill Partnership their total billed charge less any applicable share of cost. In the event a provider does not deduct the member share of cost, a retroactive share of cost audit is done to recoup the overpayment.

2. Medi-Cal Fee for Service per diem rates may be updated by DHCS from time to time for specified dates of service. The Medi-Cal Fee for Service per diem rate published for the latest dates of service remains effective for subsequent dates of service, until such time that an updated per diem rate is published for subsequent dates of service. Partnership must implement payment of the updated per diem rate on a prospective basis for all claims with applicable dates of service, received on or after 30 working days of being notified by DHCS that the updated rates are published. If additional amounts are owed retroactively in accordance with this APL and the terms of this state directed payment to a Network Provider of ICF/DD services on any claims for applicable dates of service that were processed prior to Partnership implementing the updated per diem rates on a prospective basis, then Partnership must pay any necessary retroactive adjustments within 45 working day after being notified by DHCS that the updated rates are published. Partnership must reprocess claims for specified dates of service to effectuate the updated rate automatically, without requiring manual reprocessing or resubmission by the Network Provider.

3. Payment processes including timely payment of claims requirements for Network Providers also apply for Out of Network Providers when those dates of service were under continuity of care.

D. Subacute Care Facilities – Adult and Pediatric

1. In accordance with APL 24-010, Partnership must pay timely in accordance with the prompt payment standards within our contract and APL 23-020, Requirements for Timely Payments of Claims, or any superseding APL. Fee for Service per diem rates remain effective for subsequent dates of service until an updated per diem rate is published for subsequent dates of service. Partnership will implement any changes to rates made by DHCS on a prospective basis for all claims with applicable dates of service received on or after 30 working days of being notified by DHCS that the rates have been published. Partnership will pay any retroactive adjustments within 45 working days of being notified by DHCS that the rates have been published. These retroactive adjustments will be made automatically without requiring manual reprocessing or resubmission by the provider. This applies to both contracted and non-contracted providers.

   Providers should bill Partnership their total billed charge less any applicable share of cost. In the event a provider does not deduct the member share of cost, a retroactive share of cost audit is done to recoup the overpayment.

2. Medi-Cal Fee for Service per diem rates may be updated by DHCS from time to time for specified dates of service. The Medi-Cal Fee for Service per diem rate published for the latest dates of service remains effective for subsequent dates of service, until such time that an updated per diem rate is published for subsequent dates of service. Partnership must implement payment of the updated per diem rate on a prospective basis for all claims with applicable dates of service, received on or after 30 working days of being notified by DHCS that the updated rates are published. If additional amounts are owed retroactively in accordance with this APL and the terms of this state directed payment to a Network Provider of adult or pediatric subacute services on any claims for applicable dates of service that were processed prior to Partnership implementing the updated per diem rates on a prospective basis, then Partnership must pay any necessary retroactive adjustments within 45 working day after being notified by DHCS that the updated rates are published. Partnership must reprocess claims for specified dates of service to effectuate the updated rate automatically, without requiring manual reprocessing or resubmission by the Network Provider.

3. Payment processes including timely payment of claims requirements for Network Providers also apply for Out of Network Providers when those dates of service were under continuity of care.

E. Indian Health Services (IHS)

1. In accordance with APL 17-020, Partnership is required to make payments to all contracted and non-contracted Indian Health facilities based on the established Office of Management and Budget (OMB) encounter rate or otherwise agreed to contracted rate. The OMB rates are updated on an annual basis.

   a. Claims from IHCPs will be paid in a timely and expeditious manner in accordance with federal and state laws, which dictate that 90 percent of all clean claims from practitioners be paid within 30 days of the date of receipt, and 99 percent of all clean claims be paid within 90 days of receipt.

   b. IHCPs do not need to have a contract with Partnership to receive reimbursement for services provided to an American Indian Partnership member.

   c. Partnership will reimburse an IHCP that is enrolled in the Medi-Cal program for transporting an American Indian Partnership member to an IHCP, regardless of if the IHCP is contracted with Partnership.

   d. For Medi-Cal (Partnership) beneficiaries with full Medicare coverage or Medicare Part B only, the required payment is the difference between the "Outpatient Per Visit Rate (Excluding Medicare)" listed in the Federal Register and 80 percent of the Medicare Federally Qualified Health Center (FQHC) prospective payment system (PPS) rate, as set forth in 42 USC 1395w-4(e)(6)(A)(ii).

   e. For Medi-Cal (Partnership) beneficiaries that do not have Medicare coverage or have Medicare Part A only, the required payment in the "Outpatient Per Visit Rate (excluding Medicare).

2. Tribal Health Programs, including Indian Health Services Memorandum of Agreement and Tribal Federally Qualified Health Centers, are to be reimbursed at the federally established all-inclusive rate as noted in APLs 17-020 and 21-008.

3. Urban Indian Organizations, enrolled in Medi-Cal as a Federally Qualified Health Center, are to be reimbursed through the Prospective Payment Methodology (PPS).

   Where claims processing for these services is delegated to another entity, the delegated entity must also comply with the standards outlined above.

4. Partnership is not permitted the denial of claims submitted by an IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

F. Federally Qualified Health Centers and Rural Health Clinics (FQHC and RHC)

1. In accordance with 42 USC section 1396b(m), 1396(d)(a)(17), and 22 CCR section 51345,

Partnership is required to make payments to all contracted and non-contracted FQHC's and RHC's for services provided to Partnership members at a level and amount of payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a Provider which is not a FQHC or RHC. Where claims processing for these services is delegated to another entity, the delegated entity must also comply with the standards outlined above.

G. Local Health Department

1. In accordance with APL 18-004, Partnership must reimburse local health departments for the administration fee for immunizations given to members.

2. The local health department must provide immunization records when immunization services are billed to Partnership.

3. Other than local health departments, Partnership is not obligated to reimburse providers for immunizations under this provision unless the provider enters into an agreement with Partnership.

4. Partnership must reimburse non-contracted local health departments at no less than the Medi-Cal fee for service rates for the diagnosis and treatment of a STD episode, as defined in PL 96-09. Members receiving services from non-contracted providers may elect to sign a release of confidential information; allow billing and treatment information to be sent to Partnership but not shared with the PCP or may choose not to sign the release of information. Records for services should be made available to DHCS or Partnership upon request.

5. Partnership must reimburse non-contracting local health departments at no less than the Medi-Cal fee for service rates for HIV testing and counseling in accordance with PL 97-08. Members receiving services from non-contracted providers may elect to sign a release of confidential information; allow billing and treatment information to be sent to Partnership but not shared with the PCP or may choose not to sign the release of information. Records for services should be made available to DHCS or Partnership upon request.

6. Where claims processing for these services is delegated to another entity, the delegated entity must also comply with the standards outlined above.

H. Emergency Services

1. In accordance with 42 CFR section 422.113(b), Partnership is responsible for coverage and payment of emergency services regardless of whether the provider that furnishes the services has a contract with Partnership. Partnership may not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR section 438.114(a) of the definition of emergency medical condition. Further, Partnership may not deny payment for treatment obtained when a representative of Partnership instructs the member to seek emergency services. Emergency services must not be subject to prior authorization by Partnership.

2. Partnership may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms or refuse to reimburse emergency services based on the emergency room provider, hospital, or fiscal agent notifying the member PCP, Partnership, or DHCS of the member's

screening and treatment of emergency services. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

3. Partnership must reimburse providers for emergency services received by a member from out of network/non-contracted providers. Payments to non-contracting providers must be for the treatment of the emergency medical condition, including medically necessary inpatient services rendered to a member until the member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Partnership or the member is stabilized sufficiently to permit discharge. The attending emergency physician or the provider treating the member is responsible for determining when the member is sufficiently stabilized for transfer or discharge and that determination is binding on Partnership. Emergency services must not be subject to prior authorization by Partnership.

4. At a minimum Partnership must reimburse non-contracting emergency departments and, if applicable, its affiliated providers for physician services at the lowest level of the emergency department evaluation and management physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

5. For all non-contracted emergency services providers, reimbursement by Partnership or by a subcontractor or downstream subcontractor who is at risk for out of network/non-contracting emergency services for properly documented claims for services rendered by out of network/non-contracting providers pursuant to this provision must be made in accordance with Attachment III, Subsection 3.3.5 and 42 USC section 1396u-2(b)(2)(D).

6. Disputed claims involving emergency services may be submitted for resolution under provisions of W&I Code section 14454 and 22 CCR sections 53620 *et seq.* (except section 53698) to:

   Department of Health Care Services
   Office of Administrative Hearings and Appeals
   3831 North Freeway Blvd., Suite 200
   Sacramento, Ca 95834

   Partnership agrees to implement DHCS' determination and reimburse the out of network/non-contracting provider within 30 calendar days of the effective date of a decision that Partnership is liable for payment of a claim and must provide proof of reimbursement in such form as DHCS directs. Failure to reimburse the out of network/non-contracting provider within 30 calendar days shall result in capitation offsets in accordance with W&I Code sections 14454(c) and 14115.5 and 22 CCR section 53702 and may subject Partnership to sanctions pursuance to W&I Code section 14197.7.

7. Where claims processing for these services is delegated to another entity, the delegated entity must also comply with the standards outlined above.

I. Post-Stabilization Care Services

1. Post-stabilization care services are covered by and paid for in accordance with 42 CFR section 422.113(c). Partnership is financially responsible for post-stabilization care services obtained within

or outside Partnership's network that are authorized by Partnership, subcontractor, downstream subcontractor or network provider.

2. In accordance with 28 CCR section 1300.71.4, Partnership must approve or deny a request for post-stabilization care services made by a provider on behalf of a member within 30 minutes of the request. If Partnership fails to approve or deny authorization within the required timeframe, the authorization is deemed approved.

3. Partnership is also financially responsible for post-stabilization care services obtained within or outside Partnership's network that are not authorized by Partnership. Subcontractor, downstream subcontractor, or a network provider, but administered to maintain, improve, or resolve the member's stabilized condition if Partnership, Subcontractor, downstream subcontractor, or a network provider does not respond to a request for authorization within 30 minutes; Partnership, Subcontractor, downstream subcontractor, or a network provider cannot be contacted; or Partnership, Subcontractor, downstream subcontractor, or a network provider and the treating physician cannot reach an agreement concerning the member's care. In this situation, the treating physician may continue with care of the patient until Partnership, Subcontractor, downstream subcontractor, or a network provider is reached and assumes responsibility for the member's care or one of the criteria of 42 CFR section 422.133©(3) is satisfied.

4. Partnership's financial responsibility for post-stabilization care services not authorized ends when a network provider with privileges at the treating hospital assumes responsibility for the member's care, a network provider assumes responsibility for the member's care through transfer, Partnership's representative and the treating physician reach an agreement concerning the member's care; or the member is discharged.

5. Consistent with 42 CFR sections 438.114(e), 422.113(c)(2), and 422.214, Partnership is financially responsible for payment of post-stabilization care services, following an emergency admission, at the hospital's Medi-Cal fee for service payment rates for general acute care inpatient services rendered by a non-contracting, Medi-Cal certified hospital, unless a lower rate is agreed to in writing and signed by the hospital.

    a. For the purposes of this Subsection 3.3.16 (Emergency Services and Post-Stabilization Care Services), the Medi-Cal fee for service payment amounts for dates of service when the post-stabilization care services were rendered must be the Medi-Cal fee for service payment method known as diagnosis-related groups (DRG), which for the purposes of this Paragraph 5 must apply to all acute care hospitals, including public hospitals that are reimbursed under the Certified Public Expenditure Basis methodology (W&I Code 14166 *et seq.*), less any associated direct or indirect medical education payments to the extent applicable.

    b. Payment made by Partnership to a hospital that accurately reflects the payment amounts required by this Paragraph 5 shall constitute payment in full and must not be subject to subsequent adjustments or reconciliations by Partnership, except as provided by Medicaid law and regulations. A hospital's tentative and final coast settlement processes required by 22 CCR section 51536 shall not have any effect on payments made by Partnership pursuant to this Paragraph 5.

6. Disputed claims involving post-stabilization care services may be submitted for resolution under

provisions of W&I Code section 14454 and 22 CCR sections 53620 *et seq.* (except section 53698) to:

Department of Health Care Services
Office of Administrative Hearings and Appeals
3831 North Freeway Blvd., Suite 200
Sacramento, Ca 95834

Partnership agrees to implement DHCS' determination and reimburse the out of network/non-contracting provider within 30 calendar days of the effective date of a decision that Partnership is liable for payment of a claim and must provide proof of reimbursement in such form as DHCS directs. Failure to reimburse the out of network/non-contracting provider within 30 calendar days shall result in capitation offsets in accordance with W&I Code sections 14454(c) and 14115.5 and 22 CCR section 53702 and may subject Partnership to sanctions pursuance to W&I Code section 14197.7.

7. Where claims processing for these services is delegated to another entity, the delegated entity must also comply with the standards outlined above.

J. Family Planning

1. Pursuant to federal law, including but not limited to 42 USC sections 1396a(a)(23) and 1396n(b) and 42 CFR section 431.51, Partnership must reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal fee for service rates, for services listed in Exhibit A, Attachment III, Section 5.2.8 (Specific Requirements for Access to Program and Covered Services), provided to members of childbearing age to temporarily or permanently prevent or delay pregnancy.

2. Partnership must reimburse non-contracted family planning providers at no less than the Medi-Cal fee for service rates for the diagnosis and treatment of a STD episode, as defined in PL 96-09. Members receiving services from non-contracted providers may elect to sign a release of confidential information; allow billing and treatment information to be sent to Partnership but not shared with the PCP or may choose not to sign the release of information. Records for services should be made available to DHCS or Partnership upon request.

3. Partnership must reimburse non-contracting family planning providers at no less than the Medi-Cal fee for service rates for HIV testing and counseling in accordance with PL 97-08. Partnership shall provide reimbursement only if such non-contracting family planning providers make reasonable efforts to report confidential test results to Partnership in accordance with applicable law and regulation, including but limited to H&S Code section 121025 *et seq.* Members receiving services from non-contracted providers may elect to sign a release of confidential information; allow billing and treatment information to be sent to Partnership but not shared with the PCP or may choose not to sign the release of information. Records for services should be made available to DHCS or Partnership upon request.

K. Community Health Workers

1. Community Health Worker (CHW) services will be reimbursed through a CHW Supervising Provider in accordance with its provider contract. Since CHW services are a preventive service, Partnership must not require prior authorization for CHW services: however, quantity limits can be

applied based on goals detailed in the plan of care. Partnership must not establish unreasonable or arbitrary barriers for accessing coverage. Claims for CHW services must be submitted by the Supervising Provider with allowable current procedural terminology (CPT) codes as outlined on the Medi-Cal Provider Manual. Partnership and all subcontractors and network providers must on double bill, as applicable, for CHW services that are duplicative to services that are reimbursed through other benefits such as ECM, which is inclusive of the services within the CHW benefit. Therefore, Partnership must ensure that providers do not bill for CHW services and ECM for the same member for the same time.

2. The providers' claim processes must adhere to contractual requirements related to claims processing and encounter data submissions including the use of approved codes pursuant to the Medi-Cal Provider Manual for CHW services.

3. CHWs may render street medicine, and the Supervising Provider may bill Partnership for any appropriate and applicable services within their scope of the CHW benefit.

4. Pursuant to Welfare and Institutions Code (WIC) 14087.325(d), Partnership is required to reimburse contracted Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) in a manner that is no less than the level and amount of payment that Partnership would make for the same scope of services if the services were furnished by another provider type that is not an FQHC or RHC. This requirement applies to CHW services provided to eligible members consistent with the provisions outlined in APL 24-006.

5. Partnership may structure the billing pathway as a sub-capitated rate, an add-on rate to existing payments, or another billing and payment arrangement as agreed upon with the provider.

6. Partnership will effectively implement a billing pathway for Supervising Providers, including contracted hospitals, to claim for provisions of CHW services to members during an emergency department visit and/or as outpatient follow-up to an emergency department visit.

7. The following services are NOT a covered CHW service:

    a. Clinical case management/care management that requires a license
    b. Childcare
    c. Chore services, including shopping and cooking meals
    d. Companion services
    e. Employment services
    f. Helping a member enroll in government or other assistance programs that are not related to improving their health as part of a plan of care
    g. Delivery of medication, medical equipment, or medical supply
    h. Personal care services/homemaker services
    i. Respite care
    j. Services that duplicate another covered Partnership service already being provided to a member
    k. Socialization
    l. Transporting members
    m. Services provided to individuals not enrolled in Partnership, except as noted above
    n. Services that require a license

L. Enhanced Care Management (ECM)

Partnership must pay ECM providers for the provision of ECM in accordance with the providers contracts established between Partnership and the ECM provider. Partnership must ensure that ECM providers are eligible to receive payment when ECM is initiated for any given member.

M. Mental Health Services

In compliance with APL 26-002 and Assembly Bill 1316, effective for dates of service on and after 5/1/26, Partnership covers and will reimburse providers furnishing Emergency Services, both professional and facility, and care and any Post-Stabilization Care. This does not include Specialty Mental Health Services (SMHS) provided to members admitted for inpatient psychiatric care. This is inclusive of voluntary and involuntary admission.

Partnership will ensure that all contracted Primary Care Physicians (PCPs) are authorized to issue referrals for covered Substance Use Disorder (SUD) services. A member is not required to seek a referral exclusively from their assigned PCP; any PCP participating in the member's care may facilitate the referral process to prevent delays in treatment.

VIII. REFERENCES:

A. 22 CCR, Section 51345
B. APL 18-022
C. W & I Code, Section 14184.201(b)
D. W & I Code, Section 14184.201(d)
E. W & I Code, Section 14184.201(f)
F. APL 17-020
G. 42 USC 1395w-4(e)(6)(A)(ii)
H. 42 USC section 1396b(m)
I. 42 USC section 1396(d)(a)(17)
J. APL 18-004
K. 42 CFR section 422.113(b)
L. 42 CFR section 438.114(a)
M. Attachment III, Subsection 3.3.5 (Claims Processing)
N. 42 USC section 1396u-2(b)(2)(D)
O. 42 CFR section 422.113(c)
P. 28 CCR section 1300.71.4
Q. 42 CFR section 422.133 (c)(3)
R. 42 CFR section 438.114(e)
S. 42 CFR section 422.113 (c)(2)
T. 42 CFR section 422.214
U. Subsection 3.3.16 (Emergency Services and Post-Stabilization Care Services)
V. W & I Code, Section 14166 *et seq*
W. 22 CCR section 51536
X. W & I Code, section 14454
Y. 22 CCR section 53620 *et seq.*
Z. Attachment III, Subsection 3.3.16.A.3 (Emergency Services and Post-Stabilization Care Services)
AA. 42 USC section 1396a(a)(23)
BB. 42 USC section 1396n(b)
CC. 42 CFR section 431.51
DD. PL 96-09

EE. PL 96-08
FF. APL 21-008
GG. APL 24-002, pages 8 & 9
HH. APL 24-006
II. W & I Code, section 14087.325(d)
JJ. APL 26-002
KK. Assembly Bill 1316

IX. DISTRIBUTION:
A. PARTNERSHIP4ME PowerDMS Policies & Procedures

X. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Claims Department

XI. REVISION DATES: 9/1/25, 9/1/26